



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

John Davis, D.C.

Respondent Name

Sentry Casualty Company

MFDR Tracking Number

M4-17-0748-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

November 16, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "99456 W5 WP MMI = 350.00
IR w/ ROM = 300.00
Total Paid = 350.00
Balance Due = 300.00"

Amount in Dispute: \$300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have made additional payments"

Response Submitted by: Sentry

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 26, 2016	Designated Doctor Examination	\$300.00	\$300.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §127.100 sets out the procedures for certification of designated doctors.
3. 28 Texas Administrative Code §130.1 sets out the requirements for certification of maximum medical improvement and impairment rating.
4. 28 Texas Administrative Code §133.10 sets out the requirements for a complete medical bill.
5. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services from March 1, 2008 until September 1, 2016.

6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - A90 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
 - P12 – Workers’ compensation jurisdictional fee schedule adjustment.
 - 505 – MMI/IR Certification denial due to blank or unverifiable provider license in header.
 - B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.

Issues

1. Are Sentry Casualty Company’s denials of payment based on license and certification supported?
2. Is John Davis, D.C. entitled to additional reimbursement?

Findings

1. John Davis, D.C. is seeking an additional reimbursement of \$300.00 for a designated doctor examination to determine maximum medical improvement and impairment rating, represented by procedure code 99456-W5-WP. Sentry Casualty Company (Sentry) denied the disputed services, in part, with claim adjustment reason code 505 – “MMI/IR CERTIFICATION DENIAL DUE TO BLANK OR UNVERIFIABLE PROVIDER LICENSE IN HEADER.” 28 Texas Administrative Code §133.10(f)(1)(U) requires that the

rendering provider's state license number (CMS-1500/field 24j, shaded portion) is required when the rendering provider is not the billing provider listed in CMS-1500/field 33; the billing provider shall enter the 'OB' qualifier and the license type, license number, and jurisdiction code ...

Review of the submitted information finds that Dr. Davis provided his license number in field 24j of the CMS-1500. Sentry’s denial for this reason is not supported.

Sentry also denied the disputed services, in part, with claim adjustment reason code B7 – “THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE.” 28 Texas Administrative Code §127.100 sets out the requirements for certification of designated doctors and 28 Texas Administrative Code §130.1 defines who is authorized to perform examinations to determine maximum medical improvement and impairment rating. 28 Texas Administrative Code §134.204(j)(2) states:

An HCP shall only bill and be reimbursed for an MMI/IR examination if the doctor performing the evaluation (i.e., the examining doctor) is an authorized doctor in accordance with the Act and Division rules in Chapter 130 of this title.

After review of available information, the Division concludes that Dr. Davis was certified as a designated doctor on the date of service and was authorized to perform the examination in question. Sentry’s denial for this reason is not supported.

2. Per 28 Texas Administrative Code §134.204(j)(3), “The following applies for billing and reimbursement of an MMI evaluation... (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350.” The submitted documentation supports that Dr. Davis performed an evaluation of Maximum Medical Improvement. Therefore, the MAR for this examination is \$350.00.

Per 28 Texas Administrative Code §134.204(j)(4), “The following applies for billing and reimbursement of an IR evaluation. ... (C)(ii) The MAR for musculoskeletal body areas shall be as follows. ... (II) If full physical evaluation, with range of motion, is performed: (-a-) \$300 for the first musculoskeletal body area.” The submitted documentation supports that Dr. Davis provided an impairment rating, which included a musculoskeletal body part, and performed a full physical evaluation with range of motion of the left shoulder. Therefore, the MAR for this examination is \$300.00.

The total MAR for the disputed services is \$650.00. Sentry paid \$350.00. An additional reimbursement of \$300.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$300.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$300.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____ Signature	Laurie Garnes _____ Medical Fee Dispute Resolution Officer	February 3, 2017 _____ Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.